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ABSTRACT

Ignorance, misinformation, and a failure to personalize the risk for acquisition of the Acquired Immune Deficiency Syndrome (AIDS) virus has created a situation in which the incidence of Human Immunodeficiency Virus (HIV) seroprevalence among minority childbearing women in a Florida county is increasing. An increased incidence in this population yields an increased incidence of perinatal AIDS transmission and hence pediatric AIDS. Perinatal AIDS transmission is disproportionately represented by African American and Hispanic women nationwide and this county is no exception. An educational program on AIDS, targeted at minority childbearing women, was implemented in an attempt to enhance the women's knowledge regarding the disease. Subjects (N=127) were antepartum or postpartum patients. A video which featured the testimony of three peer women who had AIDS or were infected with HIV was used to disseminate information. Five major categories of instruction were included: dispelling myths; children and AIDS; transmission of the virus, condoms; and personalizing the risk. Following the video, county statistics were given to validate and further personalize the risk. Human Immunodeficiency Virus testing was discussed and a condom demonstration was performed in an attempt to equip the participants with actual steps which can be taken towards protection. Evaluation data indicated that the project was successful in enhancing the knowledge base of the majority of the participants. (Author/ABL)

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Designing and Implementing an Educational Program on AIDS for Minority Childbearing Women to Enhance AIDS Awareness

by

Gail M. Nimphius

Cohort 41

A Practicum Report Presented to the National Master's Program for Child Care Administrators in Partial Fulfillment of the Requirements for the degree of Master of Science

NOVA UNIVERSITY

1991

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May 24, 1991
Date

Gail McKinney Kuhn
Signature of Student

Abstract

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Descriptors: Acquired Immune Deficiency Syndrome / Disease Control / Communicable Diseases / Perinatal Influences / Females / Child Health / Infant Mortality / Health Education / Health Promotion / Adult Education / Instructional Films / Peer Teaching / Peer Influences / Cultural Influences / Blacks / Hispanic Americans / Minority Groups / High Risk Persons / Program Design

Ignorance, misinformation and a failure to personalize the risk for acquisition of the AIDS virus, has created a situation where the incidence of HIV seroprevalence among minority childbearing women in the county is increasing. An increased incidence in this population yields an increased incidence of perinatal AIDS transmission and hence pediatric AIDS. Perinatal AIDS transmission is disproportionately represented by African American and Hispanic women nationwide and this county is no exception.

The author designed and implemented an educational program on AIDS targeted at minority childbearing women, in an attempt to enhance their knowledge base regarding the disease and take them to a stage where they begin to consider themselves to be at risk for acquiring it. The major vehicle utilized for the dissemination of information was a video, which was developed with the assistance of peer female PWAs and HIV infected women. The testimony of three of these women was incorporated into the video. Five major categories of instruction were addressed and included: Dispelling Myths, Children and AIDS, Transmission of the Virus, Condoms, Personalizing the Risk.

Following the video, county statistics were given to validate and further personalize the risk. A discussion regarding HIV testing was then provided and a condom demonstration was performed in an attempt to equip the participants with actual steps which can be taken towards protection.

Practicum evaluation data indicated that the project was successful in enhancing the knowledge base of the majority of participants. Related materials appended.

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VERIFICATION FORM

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Dear Verifier:

Practicum students in Nova's Master's Program for Child Care Administrators are asked to provide field-based verification that the project activities reported in their final practicum documents took place as described. You have been designated verifier to fulfill this confirmation function by the student named below. On this form, then, please write a note attesting to your knowledge of the project activity described in the final practicum report to which this will be attached. (Note that you are not asked to evaluate, nor make judgements about the quality of the project.)

Ms. Nimphius implemented the above named practicum for a period of ten weeks at a major acute care hospital. I verify that the practicum activities as stated in the final report, took place as described.

Practicum Title: Designing and Implementing an Educational Program on AIDS for Minority Childbearing Women to Enhance AIDS Awareness

Student's Name: Gail M. Nimphius

Cohort: 41

Date: _____

Verifier's Name: Antonio G. Mata, MD

Verifier's Position: Pediatrician

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Lake Worth, Florida, 33460

Chapter 1

BACKGROUND

Hospital and Community Setting

The practicum setting was a not for profit, 378 bed acute care hospital located in the southeast section of the United States. The facility employs 1800 people, has a medical staff of 450 and is the 19th largest employer in the county where it is located.

The hospital was founded in 1938, by an Order of Franciscan Nuns, who sought to provide quality care to all in the community who required it, regardless of race, color, creed or economic status. This community dedication has been upheld throughout the past several decades and is exemplified by the hospital's provision of services to a large percentage of the county's socioeconomically disadvantaged. In addition, the hospital is viewed as a leader in the health care community, as a wide range of services are provided through the utilization of state of the art equipment and a staff of professional experts.

The perinatal department of the hospital is viewed as one of the regions leading institutions for maternal/child health care delivery. This department is comprised of the following services: high risk antenatal services, where a perinatologist oversees the care of the high risk pregnancy both mother and fetus; level III neonatal intensive care services, where neonatologists and a interdisciplinary team of experts care for critically ill newborns, enabling the hospital to be

designated as one of nine Regional Perinatal Intensive Care Centers in the state; and single room maternity care (pioneered at this hospital), where bonding and mother and baby unity throughout hospitalization is designed for and encouraged.

In 1990, the perinatal department witnessed the delivery of over 4,700 babies, accounting for greater than one-third of all babies born in the county. Of this total number of deliveries, 552 babies required neonatal intensive care services. Babies who require the complex care which a neonatal intensive care unit (NICU) can offer, may include both those babies born at term, as well as those born prematurely. These infants may have respiratory ailments necessitating placement on mechanical ventilators; they may be born with congenital defects or anomalies requiring medical and or surgical interventions; they may be stressed during pregnancy, labor and or delivery rendering them ill prepared to make the successful transition from fetal to extrauterine life; or they may be born with a life threatening infection or drug addiction. These sick newborns are cared for in either the level II or level III nurseries of the NICU, based on their degree of illness. Critically ill babies are cared for in the level III nursery, whereas, moderately ill babies or babies recovering from a critical illness are cared for in the level II nursery.

The Author's Role in the Hospital Setting

The author works in the NICU in the capacity of neonatal nurse practitioner. Her educational preparation for this position includes a Bachelors and Masters Degree in Nursing, as well as an Advanced Practice Registered Nurse Certification. Her role in the NICU is to assist in the medical management of the sick

newborn through the supervision of a neonatologist. The author predominantly renders these services to the babies who are in the level II nursery. As the babies are discharged from the level II nursery, much of the discharge planning for these often fragile infants, occurs while the child is in this unit. The author is therefore intimately involved in this discharge process and is a member of a multidisciplinary team comprised of social workers, developmental psychologists, physical therapists, nurses, physicians, educators and parents, who assist in the coordination of services for the child upon discharge. As the parents are a vital and integral component of this discharge planning process, the author spends a significant amount of time working with the parents of the special needs and or high risk newborn.

Chapter 2

STUDY OF THE PROBLEM

On March 31, 1989, the results of a preliminary study on the prevalence of perinatal HIV transmission conducted by the Centers for Disease Control (CDC) and the State Department of Health and Rehabilitative Services (HRS) were released. This preliminary report identified the county were the practicum setting was located, to be the county with the highest incidence of perinatal human immunodeficiency virus (HIV) in the state, at a percentage of 1.15. (State Department of HRS, 1989). A follow up statement on this ongoing study was released in October of 1990 which reaffirmed the high incidence of HIV sero-prevalence in the county with a figure of .89 percent (though this number is slightly decreased from previously released figures, it was not found to be of statistical significance) (Department of HRS, 1990).

This study of HIV seroprevalence in the state's childbearing population has brought into focus several statistics which could not be ignored. To begin with, the study revealed that 0.46 percent of women delivering babies in the state each year were infected with the virus which causes Acquired Immune Deficiency Syndrome (AIDS). With the number of live births in 1989 projected at 192,000, 883 women infected with HIV would give birth to a live infant. Current medical knowledge on perinatal transmission, estimates that 30 percent of infants born of HIV positive mothers will also be HIV infected. This statistic yields approximately 265 new HIV

infected infants in the state in 1989. The projected number of births in 1990 is 200,000. With the same seroprevalence rate of 0.46 percent, 920 HIV infected mothers would give birth to approximately 276 infected babies in 1990.

To further illustrate this growing crisis in the community, nationally, four percent of persons with AIDS (PWAs) are infected through heterosexual intercourse. In the state where the practicum setting was located, this number rises to seven percent and escalates to 13 percent in the county. As of December, 1990, 22 percent of the reported PWAs in the county were women. This number was not broken down by age, however nationally, 85 percent of all women with AIDS are of childbearing age (Washam, 1991). It is therefore not difficult to understand why 78 percent of the nation's 2,786 confirmed pediatric AIDS cases, acquired the disease in the perinatal period.

As a result of all these statistics, what was being seen on a more human level, was a rapidly increasing number of children in the community who were suffering and dyeing with AIDS. As of December 1990, the state reported 386 confirmed pediatric AIDS cases (children less than 13 years of age). Fifty four of these children reside or resided in the city were the practicum was located. This figure ranked the city seventh in the CDC's national list of metropolitan areas with the highest incidence or pediatric AIDS (0-12 years of age) (Pediatric AIDS Campaign, 1990). Furthermore, according to data released on May 1, 1991, by the county's AIDS Surveillance Report, 67 percent of these children, or 41 of the now 61 confirmed cases, had already died from this disease. The only identifiable

risk factor for all of these children, was an HIV positive parent. (County AIDS Surveillance Report, 1991).

The study on seroprevalence of HIV also revealed what was perhaps the most insightful statistic in terms of prevention. The study revealed there to be an increased incidence of HIV infection in Black women in comparison to Caucasian women (Hispanic women were not separately identified in the study). The HRS/CDC study found Black women to be ten times more likely than Caucasian women to be infected with the virus which causes AIDS (Department of HRS, 1990). This finding of disproportionate prevalence by race, was in accordance with a nationwide statistic which found African-American and Hispanic women accounting for nearly 75 percent of all diagnosed AIDS cases in women (Valdiserri, 1989). To further complicate the issue, research conducted at the University of California, San Francisco, revealed that 50 percent of infected women do not even know that they are at risk for infection (Communication Technologies, Inc., 1986).

The major modes of HIV transmission in women, have been identified to be intravenous drug use (IVDU) and unprotected sexual contact with intravenous (IV) drug users. To substantiate this statement statistically, Amaro, 1988 cites the 1988 CDC report on heterosexual transmission, which found that greater than 52 percent of women diagnosed with AIDS, acquired the disease through IVDU. An additional 21 percent had sexual contact with men at risk for AIDS (IV drug users or bisexual men). Undeniably, an association exists between IVDU and heterosexual HIV transmission.

To explain the disproportionate representation of both IVDU and therefore HIV infection in these minority women, one must look to the inner cities of America. The incidence of IVDU among minority inner city individuals is in concert with the rise in joblessness and poverty found in America's inner cities today. Analyzed further, a corollary can therefore be drawn between an increased incidence of IVDU and the socioeconomically disadvantaged. An increase in HIV transmission fits into this equation because of certain behaviors of the IV drug user. Knowledge from medical research on the transmission of the AIDS virus tells us that the disease is spread or transmitted through the sharing of blood and or bodily fluids known to be highly infected with the virus (namely, semen and vaginal secretions).

The IV drug user therefore has an increased propensity for acquisition of the virus because of the practice of certain high risk behaviors. More often than not, IV drug users share drug needles and syringes. The sharing of these instruments is multifactorial. Essentially, it evolves from a lack of availability, as well as a lack of funds with which to acquire these tools. However, further investigation into the problem reveals that this practice also has psychological significance. Needle sharing takes on a form of socialization for the drug user (this is especially true for the new addict) and signifies a camaraderie among users (Valdiserri, 1989).

Another high risk behavior which the IV drug user may practice, is that of prostitution. Drucker (1986), points out that a substantial number of female IV drug users support themselves and their habit through prostitution.

It has also been identified, as cited previously, that women who themselves are not IV drug users, nor prostitutes, but are solely the female sexual partners of IV drug users are also at increased risk for HIV infection. In fact, one study of New York IV drug users, conducted by Des Jarlais and Friedman in 1987, found that almost 80 percent of male IV drug users had female sexual partners who did not themselves inject drugs.

So this final statistic on the state's disproportionate prevalence of HIV infection in minority women, is merely a reflection of the nationwide problem which exists. The high risk behaviors of the IV drug user and the increased propensity for IVDU in minority populations in our inner cities, has created the increased prevalence of HIV infection in this population of women. Contributing to the problem of HIV infection, is the recorded psychological profile of a significant percentage of these women. Women who find themselves involved with IVDU have historically, been women with low self esteem, women who perceive themselves to have little control over their lives and women who feel a resultant sense of power-lessness. To further perpetuate problems from a health care perspective, these women also tend to view the effectiveness of health care interventions skeptically (Valdiserri, 1989)

In analysis of these complex societal issues, one comes to the realization that AIDS, or any disease for that matter, is more than the infection of an individual. Disease is also a reflection of the ways in which we live as a society, the morals and values which we hold and the interrelatedness of all the elements of society on the disease (Valdiserri, 1989: 281).

Chapter 3

GOALS AND OUTCOME OBJECTIVES

The dramatic rate of increase in the numbers of women in the county as well as in the nation, who have acquired the HIV infection, is staggering. With the majority of these women being of childbearing age, the number of pediatric AIDS cases is also soaring. The over representation of this disease among minority women and women who are involved with IVDU, further complicates the problem, as the health care community has historically had difficulty in reaching this population. As a health care provider, the author could not ignore the alarming statistics which these HIV/AIDS surveillance reports brought into focus. The responsibility to implement measures designed to decrease the incidence of perinatal HIV transmission and hence, decrease the number of pediatric AIDS cases was therefore assumed. The author developed an AIDS educational program targeted at minority women of childbearing age. The goal of the program was to educate these women about HIV infection and AIDS, taking them from a pre-contemplation phase regarding the disease and their risk for acquiring it, to a contemplation phase.

In accordance with the American Public Health Association's Ad Hoc Work Group on Criteria for the Development of Health-Promotion and Education Programs, as cited by Valdiserri, "a health promotion program should reflect a

consideration of the special characteristics, needs and preferences of its target groups" (Valdiserri, 1989: 292). Therefore, the first objective of the educational program was to identify, over a six week period of time, what HIV infected women and women with AIDS deemed important for other women to know about HIV infection and AIDS. This objective was accomplished through the development and utilization of a questionnaire (Appendix A: 60) which addressed these issues. The objective was also accomplished through interviewing HIV infected women and female PWAs. A total of six women participated in this process and the data obtained was utilized in the development of the program. The interviews took place in both the group setting and on an individual one on one basis. The group setting was valuable for information retrieval, as women who would not subject themselves to a one on one encounter shared some of their feelings. The one on one sessions provided the author with an opportunity to build a trusting relationship with each woman. Three of the four one on one participants went on to share their thoughts and feelings before the video camera. The information therefore lent by interview was felt to be valid, as it was an accurate reflection of reality for each individual interviewed. The responses to the questionnaire were deemed reliable only if three out of six women answered in a similar fashion.

The remainder of the desired outcomes for the educational program were implemented over a ten week period of time and were evaluated through the use of a pre and post test tool (Appendix B: 62) administered to the target population. The additional objectives projected for this practicum included the following:

1. To dispel commonly held myths regarding HIV infection and AIDS

2. To increase the level of knowledge regarding the modes of HIV transmission

3. To enhance awareness of HIV infection and AIDS in children

4. To improve the level of knowledge regarding the mechanics of condom use and application

5. To personalize the risk of AIDS

The pre and post test evaluation tool, utilized to measure these objectives was comprised of a total of 25 questions. There were five questions per each of the five educational foci of attention for this target population with the program objectives arising from these five areas. The instructional areas included: The modes of transmission (how the disease is spread); provision of accurate information (dispelling the myths surrounding AIDS); children with HIV infection and AIDS; condoms (the importance of use, as well as the mechanics of application); and personalizing the risk of HIV infection and AIDS.

An improvement in pre and post test scores of 20 percent or greater was hoped for and was defined as one additional question answered right, on the post test, in one of each of the five categories of instruction, or an overall increase of five additional questions answered correctly. Utilization of a pre and post test to evaluate knowledge acquisition was the best measurement tool for the objectives, given the limited exposure to the population and inability to follow up the population after implementation.

The importance of each of these objectives in achieving the overall goal, was analyzed. Historically, AIDS has been perceived as a disease of gay white men. As a result, the past has been laden with a propensity of the masses to simply ignore a disease which predominantly does not affect them. In addition, because the disease was first recognized in the gay population, the disease has been entangled with prejudice. Why these points were relevant, to the program were as follows. To begin with, many individuals, especially those who have not been afforded the opportunity to be educated about the disease, still do not perceive themselves to be at risk for acquiring it. Second, ignorance about this disease abounds because the masses have not taken it as their own. From ignorance, myths or falsehoods about AIDS have developed rendering many to be completely misinformed. The need for accurate information about AIDS is essential in decreasing the spread of this disease. In addition, research on the subject has revealed that decreasing misconceptions about HIV infection and AIDS has increased the general population's empathy for those infected. Furthermore, individuals who were more well informed, were less likely to support government restrictions on people with the infection, such as quarantine or mandatory testing (Congress of U.S., Office of Technology Assessment, 1988).

In analyzing the need to enhance knowledge regarding the modes of transmission, the only way to stop the spread of the disease is to educate about the disease and how it is spread. Information on transmission of AIDS is directly related to condom education. One of the primary ways which we can stop the spread of this disease is to practice safe sexual behaviors. Latex condoms have

been found to be extremely beneficial in decreasing the spread of all venereal diseases, and HIV is no exception. Childbearing age, sexually active individuals must be educated about condoms and the mechanics of application. Finally, enhancing the target population's knowledge of babies and children with AIDS, provides these women with the information they need to have in order to make informed decisions about childbearing.

Chapter 4

SOLUTIONS AND STRATEGIES

Information Collection

"I have AIDS, and AIDS is not my problem. AIDS is your problem. Through better education, we can prevent a single additional person from getting the AIDS virus" (Bartlett, 1987:18). The words of an unnamed 34 year old man with AIDS, shortly before his death. The necessity and urgency of educating sexually active individuals about HIV infection and AIDS is apparent. The challenge comes in developing programs which are both culturally and linguistically salient to each population being targeted.

Developing educational programs on HIV infection and AIDS is indeed a challenge. The literature abounds with identified barriers to education. These barriers range from difficulty in communicating information about a disease which is transmitted sexually, to the cultural barriers associated with the minority populations who over represent this disease statistically. One cannot merely approach AIDS education from the vantage point that all that is needed is to relay the information and the behavior changes will follow. This decision making theory was not valid for the target population as it is based on rational actors whose priorities may not be where their next fix is coming from, or the fear that if they do not abide by their partners wishes, they and their children will be out in the street.

Having knowledge of risky behavior does not automatically dictate or assure that actions will be taken to decrease risky activities as this theory implies. Furthermore, this approach demands that the target population perceive HIV infection to be a threat with severe consequences, before education begins. Unfortunately, for many in the population being targeted, this is not the case, as many in this population have not yet personalized their risk for HIV infection.

From these statements, it became evident that instead of a decision making theory approach, the approach taken to AIDS education would have to be one based on an in depth understanding of the target population. An individual's "socioeconomic status, cultural values and language are all factors which influence attitudes, beliefs, behaviors and access to health information and services" (Amaro, 1988: 430). Therefore, as Shaw and Paleo, 1986 pointed out, in order to be effective, an AIDS prevention program must be both culturally and linguistically appropriate. Failure to be adequately informed about the psychosocial and cultural aspects of the target population have been identified as barriers to effective education and intervention (Sutton-DeBarros, 1989). In order to avoid these barriers peers and culturally aware individuals need to be incorporated into program planning. These individuals lend great insight into the target population's priorities and in addition, they can be utilized in the dissemination of information.

The experiences of the Association for Drug Abuse Prevention and Treatment (ADAPT) prove helpful in the development of such programs. ADAPT pioneered the now successful use of community volunteers, familiar with the drug subculture, (often because they themselves are ex-users) to impart drug

information to the target population. Because these individuals were intimately familiar with the target population's way of life and priorities, the information that they provided was more readily accepted by this population. This lends credence to the following statement by Valdiserri (1989: 70): "AIDS risk communication must be provided either by a source that is credible to the high risk group, on their own terms or by a source that the group likes or respects". This point must be well taken by peers and professionals alike, who may be involved in the instructional process. Some of those in the target population, may associate health care professionals with authority figures who have in the past chastised or penalized them for their IV drug use or other illegal behaviors. As these illegal behaviors are also the high risk behaviors which the health care professionals seek to change, the at risk individuals may be angered and as a result disregard the prevention messages. To overcome situations of this nature, it can be helpful to utilize peer victims in the educational process as alluded to above. It may also be helpful to include minority professionals in the dissemination of the information. The practice of consistently portraying minority individuals as victims and non-minorities as professionals, has the propensity to evoke fear and denial in the target population, lower an already tenuous self esteem and at the very least, would be a false representation of reality (Gilliam, Scott, and Troup, 1989).

Another strategy in AIDS prevention programs is the utilization of peers as role models. It has already been established that many HIV infected women became infected through association with IV drug use. Common characteristics of these women include low self esteem, a sense of powerlessness and a feeling

of having little control over their lives (Valdiserri, 1989). As a result, even when provided with information about risky behaviors, these women may have reason to doubt their capability to change the behaviors which place them in jeopardy of acquiring the infection. These women have a low self efficacy. Self efficacy, as explained by Bandura and as cited by Valdiserri (1989), refers to an individual's belief in what they can or cannot do. Therefore, individuals with a low self efficacy, would perceive themselves to be unable or unequipped to effect the desired change. Hence, regardless of the extent of education or the perceived threat of disease, these women will do little to change their behaviors if they doubt their own self efficacy. However, as Mondanaro, 1987, points out, the use of positive role models can help change these women's behaviors. Positive role models can enhance the target population's perception of their own self efficacy by providing them with evidence that self protection can be successful.

Another method employed to enhance the target population's self efficacy, is to provide these individuals with actual steps that can be taken toward achieving behavior change. It is simply not sufficient to state that risky behaviors need to be changed, individuals must also be provided with specific instructions on how to change (Valdiserri, 1989).

Providing specific instructions is also essential in reducing the fear which may be aroused in the individual when AIDS information is provided. Certainly, there are many theories advocating the role of fear as a stimulus toward behavior change. However, fear has also been proven to produce dysfunctional effects which can actually interfere with behavior change. Such dysfunctional effects may

include a fatalistic approach where the individual feels helpless, has avoidant thinking and/or denial. All of these responses have been associated with AIDS prevention messages. The ways in which to overcome fear and the resultant dysfunctional effects that AIDS education can evoke, is to provide the target population with accurate information, dispel any myths which are contributing to fears and provide the individuals with options and specific solutions toward self protection (Gilliam, Scott, Troup, 1989).

Another strategy utilized in AIDS educational programs, which relates back to having an in depth understanding of the target population, is to deliver the messages in ways and terms which the population can identify with and understand. McGuire, as cited by Valdiserri (1989), suggests that persuasion can be enhanced by providing information at or below the reading level of the target group. This investigator goes on to state that the general population prefers information transmitted via television as opposed to that relayed in written text. However, printed information stimulates more thought regarding the topic and more learning. Finally, having the source of information physically available in the setting, is preferred over sources presented in print or electronically. Gilliam, Scott, and Troup (1989), reinforce these assertions.

The setting for the instruction is also a consideration in developing an AIDS educational program and in fact, can be a strategy toward effective dissemination of information. Sutton-DeBarros (1989), lists inconvenient location, a lack of transportation and a lack of child care, as some of the identified barriers to effective care and education. Valdiserri (1989), believes that often times, the best

place to educate about high risk behavior and prevention, is to go to the environment where the behavior takes place (for example, IV 'shooting galleries' and neighborhoods where the prevalence of IV drug use is high).

Drucker has cited success with AIDS prevention programs carried out in drug rehabilitation centers. However, as "...only between 15 and 20 percent of current addicts are enrolled in care" (1986: 176), other settings must be pursued to reach a larger percentage of this population of high risk individuals. Viable alternatives include: primary health care facilities, emergency departments and clinics. Gilliam, Scott and Troup (1989), advocate using health agencies which low income and minority populations attend. In contrast, Valdiserri (1989), points out that the clinic setting may not be ideal for the dissemination of AIDS prevention information. The reason given is that several disease prevention/health promotion messages will be given simultaneously in this environment. One's ability to retain all the information provided, is seen as marginal.

The final important strategy which must be addressed in an AIDS prevention program is the provision of information on condoms. Teaching about condoms fulfills the requirement of assuring that the target population is given specific means and instruction on what they can do to protect themselves from infection. However, information about condoms is a separate strategy, because historically condoms have been the subject of controversy, have been associated (however wrongly) with promiscuity and because there are significant cultural beliefs which interfere with condom use.

There are essentially three broad categories of barriers to condom use which research has identified. These categories include objective barriers, situational barriers and subjective barriers. From an objective perspective, the lack of availability or access to condoms is seen as a barrier. This can be alleviated through health educators supplying condoms free of charge. There are two situational variables. These include failure to plan ahead for the intimate encounter (not being equipped with the condoms) and the use of alcohol and/or drugs prior to the encounter. The latter, has the propensity to either cause the individual to disregard condom use or to use condoms incorrectly. Subjective barriers to condom use include subjective opinions such as a perceived belief that condoms interfere with sexual pleasure, are unnatural, are offensive or are unacceptable because of their association with promiscuity and prostitution (Valdiserri, 1989).

These subjective barriers are particularly prevalent in the Hispanic and African-American cultures. For the Hispanic population, in general, the act of sexual intercourse is solely for procreation. Therefore the use of birth control in any form denotes negative cultural values. Furthermore, birth control negates the cultural importance of motherhood. As a result, Hispanics strongly relate condom use with promiscuity and prostitution (Bartlett, 1987). While there have been studies conducted with Hispanic women, whose findings dispute these cultural mores and report Hispanic women taking initiative with contraception, the National Center for Health Statistics (NCHS) as cited by Amaro (1989), reports very low usage of contraception among these women.

The subjective barriers to condom use also exist for African-American women. In this culture, the role of motherhood takes on great importance and enhances feelings of self esteem. Furthermore, there are traditional values which discourage women from questioning the motives of men, particularly in reference to sexual practices. For these varied reasons, condom utilization is often viewed as unacceptable (Valdiserri, 1989).

Objective, situational and subjective barriers are all extremely important to consider when developing programs which will address condom use. By identifying these barriers ahead of time, strategies can be developed to combat them. Bartlett (1987), suggests performing a 'behavioral diagnosis' of the target population before condom education, so that the individual's current practices and beliefs can be ascertained. Valdiserri (1989), asserts that the most appropriate initiative in this regard is to present these safe sex practices as being socially acceptable and use peer role models to reinforce this assertion.

Strategy Decisions

A thorough review of the available literature on the subject of developing effective programs for preventing AIDS in high risk childbearing women was conducted. As a result, the following strategy decisions were made.

Before the program was developed, a considerable amount of time was spent in an effort to gain an in depth understanding of the target population. This was achieved through contacting and evoking the participation of women who were

HIV infected or female PWAs. As peer victims, these individuals afforded the author invaluable information as to the priorities of the high risk population. They also gave insight into what they believed would be the best ways to reach the target population with AIDS prevention messages. This data collection process was facilitated through the development and utilization of a questionnaire and interviews in both group and individual settings. In addition, the author also met with health care professionals working intimately with these clients. This was done in an attempt to gain their input into this complex problem and their ideas about reaching the identified target population.

Following this data collection process, a pre and post test was developed. Before implementation, this tool was evaluated for both medical accuracy and the appropriateness of language/terminology utilized. The evaluator was a Hispanic pediatrician who has worked with the high risk population for years.

The format utilized to present the AIDS prevention program was a video. This video format was chosen as the vehicle for dissemination of information for several reasons. First, this media had the capability to reach all those English speaking individuals in the target population, regardless of their ability to read (unfortunately however, the evaluation tool could not be used to ascertain enhancement of knowledge in those who could not read or could not read English). In reference to those individuals who could not understand English (Hispanics, Haitians, one Israeli women, one African women and one Japanese women), the restraints of resources, time and finances inhibited their benefit of the information provided to their English speaking peers.

The second reason guiding the use of this particular media, was that television has been documented as an effective means of transmitting information (McGuire, as cited by Valdiserri, 1989). Furthermore, this vehicle would enable the target population to hear and see peer victims of HIV infection and AIDS. This could not have been accomplished through any other media and the importance of inclusion of such victims in an educational program, has already been documented in the previously (Gilliam, Scott and Troup, 1989 and Valdiserri, 1989). In addition, peer victims serve as positive role models for the target population as they discuss their struggles and triumphs in changing their high risk behaviors, in regaining their self esteem and in their ability to live with HIV infection and AIDS. In an effort to further enhance the validity of the information for the target population, minority professionals presented much of the video's critical information.

In order for any prevention program to be successful, the target population must perceive themselves to be at risk. The video attempted to accomplish this through the provision of factual information about the disease and how it is spread, dispelling any previously held myths. However, before one can perceive themselves to be at risk, they must personalize the risk. The author attempted to do this through gaining an understanding of the population through interviews with peer victims and then incorporating this information in the video script. In addition, the author included the testimony of peer victims in an effort to further personalize the risk of infection.

As reiteration of material has also been found to be successful in the retention of that material, information regarding condoms was provided twice (during the video and following it, in the form of a condom demonstration) (Valdiserri, 1989). Condoms play a significant role in decreasing the spread of this disease and safe sex practices are actual steps which the target population can perform, to protect themselves from acquiring infection. Condom use was presented as socially acceptable and was presented with respect given to the three identified barriers to effective condom use (Amaro (1988), Bartlett (1987), Valdiserri (1989). This was accomplished through the testimony of the peer victims, as well as the utilization of a Hispanic male who discussed condoms in the video.

The video also addressed children and AIDS and included footage of babies and children with the infection. This was done in an effort to reach the target population with information on perinatal transmission. The women heard and saw how their unsafe behaviors could affect their unborn babies.

Following the video, there was a question and answer period to discuss any information which was either unclear or needed to be reiterated. During the video, the author scored the pretests. Any information consistently answered incorrectly by the participants was reiterated correctly at this time. In addition, regardless of test score results, in the area of personalization of risk, these issues were reinforced and statistics were provided for the city and county of residence. The condom demonstration was then given followed by a discussion of the need for HIV testing before future babies were conceived. A post-test was then given to

evaluate the intervention. Finally, AIDS informational brochures, both in Spanish and English, prepared by The American National Red Cross and a community resource and referral information sheet, prepared by the county's Comprehensive AIDS Program, were distributed upon closing.

The instruction setting was the area within the hospital, which provided postpartum care and high risk antepartum care to women in the target population. Other women not within the minority childbearing population, and therefore not at greater risk for acquisition of the virus, were also cared for on this floor. The participation of these individuals, as well as any individuals (such as significant others, friends, mothers or fathers) was encouraged, as the information provided was beneficial to all regardless of race, gender or financial status. It was theorized, based on the above, that the greatest exposure to the target population would be achieved in this setting.

Additional reasons supporting the location of the setting, referred back to Drucker (1986), who supported the delivery of prevention messages in primary health care facilities. Gilliam, Scott and Troup (1989), also advocated the utilization of health agencies which the population already frequented. In reference to Valdiserri (1989), regarding the noncompliance of the clinic setting because of competing health messages, by having the program in the hospital, this obstacle was avoided. There was also no additional cost incurred by having the hospital setting as the site of instruction, as Gilliam, Scott and Troup (1989) stress.

Finally, something that the literature did not address, was the need to have a teaching environment free of distractions. The postpartum floor of the hospital

proved to be a more controlled environment then most and although not free of distractions, distractions were at a minimum. The program was initially implemented after visiting hours, generally on the night before the mother went home. However, this time period was utilized for the first two weeks of the implementation process only. After the first two weeks, the classes were presented at various times of day which accommodated the nurses and babies' feeding schedules. The reason behind the change in time was that on several occasions, the participants were found to be drowsy during the later session. The lateness of the hour was felt to be a possible contributor and therefore a time change was carried out with improvement in overall alertness of the participants during the sessions. The Babies were cared for by the nurses during the classes, eliminating this possible distraction and siblings were not present.

Report of the Action Taken

Pre-Implementation Tasks:

1. The literature was reviewed for justification for conducting an AIDS prevention program in a catholic institution. A copy of an excerpt from the Administrative Board of the United States Catholic Conference, 1987 was obtained which condoned condom instruction as a "toleration of a lesser evil to prevent a greater evil" (Gallagher, as cited by Goldman, 1987: D17).

2. Contacted the Director of Perinatology and discussed the program plan gaining support for the program.

3. Met with nursing administration for permission to conduct a practicum of this nature in the hospital setting.

4. Contacted and met with nursing manager of the postpartum floor to discuss the intent of the program and the expectations of the staff, who facilitated the practicum's ongoing process.

5. Contacted the Medical Director of the County AIDS clinic to notify him of the intent of the program and gained suggestions from him regarding possible peer candidates.

6. Contacted and met with the Medical Director of the County Pediatric AIDS clinic and notified her of plans and intent.

7. Contacted and met with Nursing Director of the County Pediatric AIDS clinic to notify her of plans and intent. Gained her input on methods of approaching HIV positive mothers and gaining access to these mothers for their possible participation in this program.

8. Contacted and met with the Director of the Women's AIDS Support Group to discuss intent and to gained insight into the problem and population at risk.

9. Developed a questionnaire and cover letter for HIV infected women and female PWAs.

10. Distributed the questionnaire and cover letter to the women of the Women's AIDS Support Group.

11. Met with the ladies of the women's group who were interested in participating in the program.

12. Conducted one-on-one interviews with four of these ladies.

13. Conducted a group interview.

14. Compiled data from both interview and questionnaires.

15. Developed a pre and post-test evaluation tool.

16. Developed a video script in linguistically and culturally appropriate terms for the target population.

17. Verified evaluation tool and script for medical accuracy and language appropriateness with a Hispanic pediatrician, well versed in both Pediatrics AIDS and in caring for the high risk population.

18. Networked in community to locate individual(s) willing to assist in video production.

19 Contacted and met with an individual who had video production and experience who was willing to participate in program development.

20. Reviewed the script, ideas and concepts with video assistant and set up time table for filming of necessary footage.

21. Contacted and met with Directors of various community agencies to explain intent and gained the necessary permission to film in facility.

22. Developed a Model Release Form. (Appendix C: 64)

23. Contacted an attorney for legal counsel regarding Model Release Form.

24. Began filming after release forms signed.

25. Contacted pediatricians of ethnicity to be professionals in video.

26. Contacted the American National Red Cross and the County Comprehensive AIDS Program, to obtain AIDS prevention brochures and information to be distributed to the target population.

27. Finished filming.

28. Edited video.

29. Met with representative for the Chief Executive Officer of hospital and Nursing Administration to review and discuss the video before implementation.

30. Met with nursing staff of postpartum floor to discuss intent and review the video. Evoked participation and support of the program.

Implementation Process

The practicum was implemented three to five times a week based on patient census, for a total of ten weeks. It was carried out in an unoccupied patient room on the post partum floor. The actual number of participants per session ranged

anywhere from two to nine, however most often four to five individuals were taught at one time. The intent of the program was to provide the instruction after visiting hours to limit the amount of possible distractions and to evoke more patient participation. The practicum was implemented anywhere from nine in the evening to 11 in the evening, for the initial two weeks. After this period however, the time of day for implementation was changed as some of the participants were found to be drowsy and the time of day was felt to be a contributing factor. For the remainder of the implementation process, the instruction was given at varied times of day to accommodate the nursing staff's needs, baby feeding schedules, patient care schedules and physician rounds. Four o'clock in the afternoon and eight o'clock in the evening were two particular times of convenience for all and these time slots were utilized frequently. In fact, these time periods for instruction lent a surprising and beneficial addition to the population sample, visitors and male significant others, participated in the program on occasion. In addition, there was an overall improvement in the alertness of the participants, demonstrated by only a few additional occurrences of drowsiness for the remainder of the implementation process.

Prior to implementation of the program each day, the nurses made a list of women who were medically stable enough to attend and who spoke and/or understood English. These women were then asked if they would like to attend a video on AIDS. This method of petitioning participation had drawbacks however and required change. The drawbacks included each individual nurses approach to the patient regarding the subject matter. Some of the nurses were very

supportive of the program and encouraged patients to attend. Others however, were more reluctant and simply offered the program to the women. As a result, what was happening was many, especially those in high risk groups (substance abusers, and prostitutes) were declining the opportunity to attend the program. Upon weekly discussions with the staff, the author identified the reluctant approach of some of the nurses to be a possible barrier to reaching all those in the target population. Therefore, at the beginning of the fourth week, the author made the initial contact with all the patients. The overall participation improved somewhat, however there still existed those individuals who refused. Interestingly, many, especially those in high risk categories, were quite manipulative in their efforts to not attend, stating they were too fatigued, or they had already seen the video at the clinic. Some, but not all cooperated when the excuses given were challenged.

In a persistent effort to reach all in the target population, the author met with the Director of Perinatology at the end of the fourth week to discuss the situation at hand. This physician, who was very supportive of the program, made the program mandatory for all her patients (the majority) and also requested that the stable antepartum women with high risk pregnancies also attend. This support in making the program mandatory improved the overall participation. Though there still existed the women who attempted to manipulate themselves out of attending, the success rate for doing this became marginal. During the remainder of the implementation period, only two individuals flatly refused and did not attend.

The educational process itself began with a brief introduction as to the author's role in the hospital and why the practicum was developed. This was

followed by an explanation of the pre and post test evaluation tool and the need to complete it. Participants placed their initials on the tests so that pre and post tests could be compared for each individual. Upon collection of the tests, the tests were coded by the author in an attempt to identify the participant's race and gender. The video was then shown in its entirety. While the video was playing, the author corrected the pre tests so that questions answered consistently in error, could be emphasized correctly during the discussion which followed the video. The author also observed the participants during the video for their reactions, alertness and body language.

Questions from the participants were entertained during the discussion period which followed the video. This time was also devoted to the presentation of materials missed on the pre test as described above. In addition to this, city and county statistics were given to validate and further personalize the risk of infection. The discussion also included the provision of information regarding HIV testing. Following the discussion period, a condom demonstration was provided in an effort to reiterate this important information, as well as equip the participants with actual steps which can be taken toward protection. Just prior to the administration of the post tests, the need for HIV testing before future pregnancies, for one's own sake, as well as the sake of one's unborn child, was accentuated.

The post tests were administered and the session ended with the distribution of brochures developed by the American Red Cross. These brochures included: "Women, Sex and AIDS"; "HIV Testing"; and "HIV Infection and AIDS". To those Hispanic individuals more acquainted with reading Spanish text, a

Spanish production of "HIV Infection and AIDS" was provided. In addition, and "Information Sheet" developed by the county's Comprehensive AIDS Program, which included lists of varied services and phone numbers, was given out.

The entire session from start to finish, generally took 45 minutes to one hour, dependant upon questions from the participants. The video consumed approximately 20 minutes of this time. Twenty minutes was found to be the maximum amount of time that the majority of participants could tolerate before becoming distracted or eager to leave, as demonstrated by body language.

In an attempt to monitor the participant information obtained from the evaluation tool, the author devised a data report sheet (Appendix D: 65). The areas monitored on this sheet included: race; gender; perceived risk for AIDS on pre and post tests; pre test scores by number and percentage; category of pre test score errors; post test scores by number and percentage; category of post test score errors; overall improvement; and those participants who showed an improvement of 20 percent or greater. Data of this nature was logged into this flow sheet on a daily basis and then totaled at the end of the week. The information from this sheet was then entered into various other tables developed to keep track of all the information. Compilation of the data on a weekly basis was beneficial, as the sample size was in excess of 100.

The author also met with the staff once a week and performed weekly evaluations of their input. In addition, evaluations of the interactions of program participants and pre and post test scores was also conducted on a weekly basis. Every two weeks, the practicum was evaluated to determine: if the target

population was being reached (by reviewing the logged lists of participants and those who declined); if the time of day for the implementation was meeting the needs of the program and the unit as a whole; and if an improvement in test scores was being seen. By monitoring these areas frequently, problems could be identified and changes made to enhance the implementation process.

There was one identified problem however, in reaching the target population which could not be remedied, that of reaching the non English speaking Hispanic population. This problem was realized from the onset, however no intervention, other than providing these women with Spanish literature, could circumvent it.

Follow on

Because of the lack of effective treatment for HIV infection, the only way in which to stop the disease, is to stop the spread of the disease. Prevention is the only vehicle in which to do this. Education is the key to prevention. Education is not a task which simply starts and then abruptly ends. Rather, education is an on going process that changes and accommodates as it continues, in order to meet the specific needs of its audience.

Only a small percentage of the identified target population could possibly be reached in a ten week period of time. Therefore, continuation of this program is essential in order to truly make an impact on slowing the spread of AIDS among minority childbearing women and children in the community. If only one individual of many is reached with this information, causing a positive change in high risk behavior and hence, preventing the spread of this life threatening disease, the entire program and the efforts employed in it, are well worth all expenditures. And

since the program is already in place, additional expenditures to maintain its continuation will be marginal.

In the future, the practicum could and should be altered in order to meet the needs of all those identified in the target population. Unfortunately, because of the restraints of time and resources, both personal and financial, the practicum had to be designed to exclude those individuals who could not understand the English language. As the target population consisted of varied ethnic individuals, there were exclusions of some because of a communication barrier. In addition, although the written information was in both English and Spanish, there was no written information in Creole. For Haitian women, many barriers to AIDS education exist, ranging from language barriers to fatalistic cultural traditions which the majority of educators do not understand (Valdiserri, 1989). Reaching the Haitian population is a unique challenge yet to be pursued. The need certainly exists to develop programs specially designed for this population however, the resources are not as readily available.

Reaching the Hispanic population who do not speak English, is an easier task to accomplish. This can be achieved through interpretation of the pre and post-test into Spanish. The video through editing, could also easily be interpreted into Spanish, as many of the video participants are already bilingual. The condom demonstration, as well as the question and answer period following the video, could also as easily be conducted by members of the health care field who are bilingual.

In reference to utilization of the practicum plan at other settings, there has already been a stated interest from several local organizations. The county Comprehensive AIDS Program was contacted and is interested in pursuing use of the film in their outreach educational programs. In addition, the director is interested in utilizing the results of this practicum in an educational grant proposal. Should funding be secured, the possibility exists for professionally remaking the video, as well as producing a Spanish counterpart.

In reality, the educational program could certainly be implemented anywhere one would find the target population and adapted to meet the specific needs of a particular setting. The only resource required would be the interest and dedication of a few individuals who would undertake its implementation.

An educational program on AIDS of this nature will only begin the long process of AIDS education and awareness in the community. Hopefully, this program has prompted women to come from a pre-contemplation phase about HIV infection and their risk of acquiring it, to a contemplation phase, where they begin to think about high risk behaviors, examine their ability to avoid the behaviors and seek information on self protection (Valdiserri, 1989). To determine the participant's path along this educational awareness continuum, there must be an evaluation mechanism in place. Following the implementation of this program, community AIDS resource and referral facilities should be monitored to identify if there is an increase in utilization of their services. And, ultimately the most appropriate way to determine if women are changing their high risk behaviors, is to perform anonymous HIV testing. Anonymous HIV testing of all women at the facility, with

monitoring over time, will enable the author to ascertain if the number of deliveries to HIV positive women is decreasing.

Finally, as HIV infection is a disease which is spread sexually, any educational program targeted at women, must also be targeted at their sexual partners. Though strictly by fortune of circumstance, a few men were participants in the practicum program, more concerted efforts in this regard must begin. As Bayer (1989: 504), points out in his discussion of the ethics of prevention of perinatal HIV transmission: "...an effort to protect women without altering the attitudes and behavior of men simply won't work." Therefore, programs for men should be the next challenge in this ongoing educational process to decrease the incidence of perinatal HIV transmission.

Chapter 5

RESULTS, CONCLUSIONS AND RECOMMENDATIONS

Summary of Findings

The practicum process began with identifying what HIV infected women and women with AIDS felt was important for other women to know about this disease. A total of six women assisted in accomplishing this objective through their participation in completion of a questionnaire regarding this subject matter and their participation in an interview process with the author. Information and insight gained through this process enabled the author to develop a video script which addressed these identified needs.

The practicum process continued with the implementation of an educational program on AIDS, designed to enhance AIDS awareness in minority childbearing women. This phase of the program was conducted on the post partum floor of an acute care hospital for a total of ten weeks. One hundred and twenty seven individuals participated in the program with the greater percentage of these individuals being African American females. Fifty eight percent of the individuals who were taught were within the prescribed target population. However, because the information provided in the program was deemed beneficial to all who desired to attend, individuals who were not necessarily in the identified minority childbearing women target population, also participated. Data from these individuals was compiled with all those receiving information.

The majority of participants (87 percent) demonstrated an overall improvement in test scores, as determined by the pre and post test evaluation tool. Thirty five of the individuals, or 27.5 percent improved 20 percent or greater between pre and post test scores. For each test category, namely: Dispelling Myths; Children and AIDS; Transmission of the Virus; Condoms; and Personalizing the Risk; there was a mean percentage of improvement.

Results

Discussion of the results in detail begins with the information gained from the interview/questionnaire process directed at female PWAs and HIV infected women, in fulfillment of the first practicum objective. In response to the question what did you know about AIDS before you became infected, of the six women who completed the process, three of the six thought AIDS was solely a disease of gay men and IV drug users. One of the three was an IV drug user herself and she stated she knew about safe sex and to not share needle works, but did not practice these measures because she believed that an HIV positive individual looked sick. What she did instead, was look for 'signs' of infection in the man, before having sex or sharing needles. The other three women responded that they knew virtually nothing about the disease. One of these ladies however, contracted the disease approximately ten years ago when very little information was available.

In response to the question regarding the types of AIDS prevention information that they would have liked to have received, two of the six ladies stated information about safe sex. Of the two former IV drug users who responded, one wrote that she wished she knew that you cannot determine one's HIV status by

looking at them. The other, lady felt that she needed information about how to get help for her addiction and that she could 'stay clean'.

The third question in the questionnaire addressed the myths that the women believed prior to their diagnosis. Two of the six ladies responded that they did not think they were at risk because they were not IV drug users or homosexual. Other voiced responses included the reiteration of the myth that HIV positive people look sick and that once you become infected, death ensues quickly.

In response to the fourth question regarding the AIDS prevention messages that the women deemed important for women to know, all six of the women stressed the importance of practicing safe sex. Two of the six also recommended discussion of testing.

The fifth question asks what are the best ways to get women to practice safe sex. For this question, each woman had a somewhat different response. These responses included the following: having HIV positive women and female PWAs speak to women; showing women what can happen to them if they do not practice safe sex (i.e. visions of women and children dyeing from AIDS); reinforcing to women that the disease is fatal; implementing measures designed to enhance a woman's self esteem and self respect; and reinforcing to women the assertion that one should assume that each person they sleep with has the potential of carrying the virus and therefore they should take the necessary precautions.

The kinds of information which should be included in an AIDS teaching program was the sixth question. Again, responses were varied, with the exception

of three of the six ladies reiterating the need to teach safe sex practices. Other suggestions included: information on transmission; informing IV drug abusing women that help is available to them; discussion of testing; discussion of the difference between a person who is HIV positive and a PWA; and finally informing women that people are living with AIDS not dyeing with AIDS, affirming that life continues after diagnosis and a positive mental outlook can have a positive impact on the rate of progression of this disease.

Question seven addressed what these HIV positive and female PWAs would say to women about AIDS, about their life and about their children, if they were given the opportunity. Once again, the importance of safe sex and getting tested was a central theme. Other women reiterated the importance of a positive attitude in dealing with the diagnosis. One respondent expressed that she would not wish her life as it is now, on her worst enemy. One of the ex-users stated that: "AIDS saved my life, it got me off the streets, away from shooting and back with my family" (PWA, 1991). In reference to the children, three of the six ladies had older children who were born after they contracted the virus. These women spoke about educating their children at an early age about the risk of infection. The other three women had children with AIDS, who acquired the virus through perinatal transmission. These women stressed the importance of faith in dealing with this situation.

The final question addressed what a woman's sex partner should know about AIDS. The answer to this question was a unanimous "everything".

As stated previously, the validity of the information secured from the interview/questionnaire process was assured, as it was an accurate reflection of reality for each individual. The reliability of the information was dependant upon three of the six women responding in a similar fashion, which the ladies did on several occasions. However, any and all information provided, was utilized in the development of the video script, as these victims were deemed by the author, to the 'experts'.

The remainder of the objectives were fulfilled during the actual educational process. During this process 127 individuals were instructed (refer to the Data Report Sheet, Appendix D: 65, for the compilation of data received from each of these participants, for the ten week implementation period). As stated previously, the intended target population was minority childbearing women. This population was deemed to be comprised predominantly of African American and Hispanic females (based on local, state and national statistics). Seventy four of these 127 participants or 58.2 percent were within the prescribed target population, with 51.2 percent or 65 of these ladies being Black females (Chapter Four makes reference to the reasons behind the limited number of Hispanic female participants and also explains why individuals, other than those in the prescribed target population participated in the practicum). The remainder of the participants included Caucasian females, Caucasian males, Hispanic males and one Haitian male. There were no Haitian female participants. Figure One depicts the distribution of the participants by race and gender:

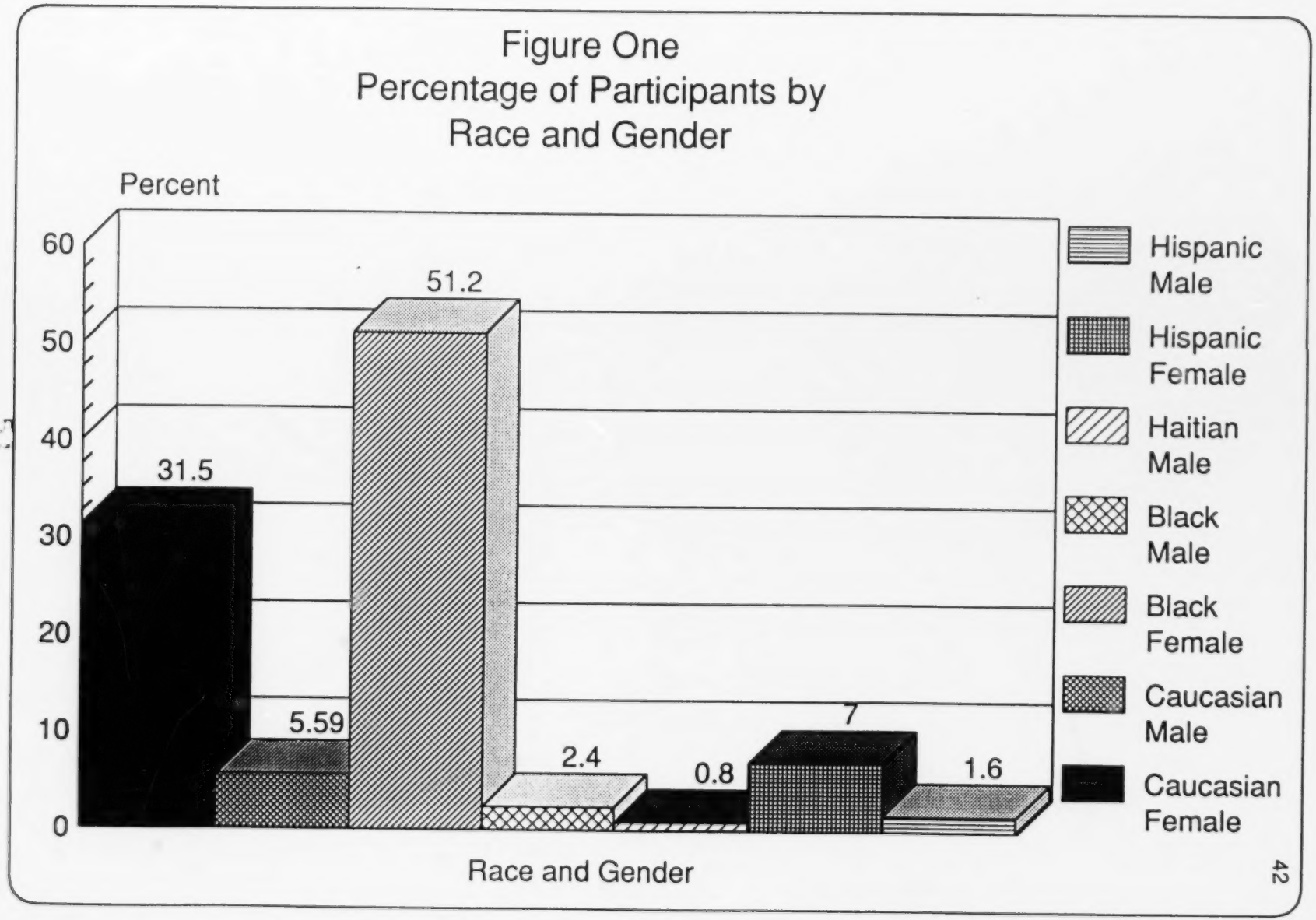


Figure One
Percentage of Participants by
Race and Gender
Percent
60
50
40
30
20
10
0
31.5
5.59
51.2
2.4
0.8
7
1.6
Hispanic Male
Hispanic Female
Haitian Male
Black Male
Black Female
Caucasian Male
Caucasian Female
Race and Gender

The design of the practicum was such that fulfillment of the objectives would be measured by an improvement of 20 percent or greater on pre and post test scores. This would be evidenced by either an overall increase of five additional questions answered correctly on the post test, or one additional question answered right in one of each of the five categories of instruction. Thirty five, or 27.5 percent of the participants demonstrated an improvement of 20 percent or greater. Twenty three participants or 18.1 percent, showed an improvement on post test scores to 100 percent. These individuals, however could not enhance their scores by greater than 20 percent, as their pre test scores were 84 percent or higher. Though the percentage of improvement by this definition was not as great as originally anticipated, the majority of participants demonstrated an overall improvement as shown in Table One:

Table One

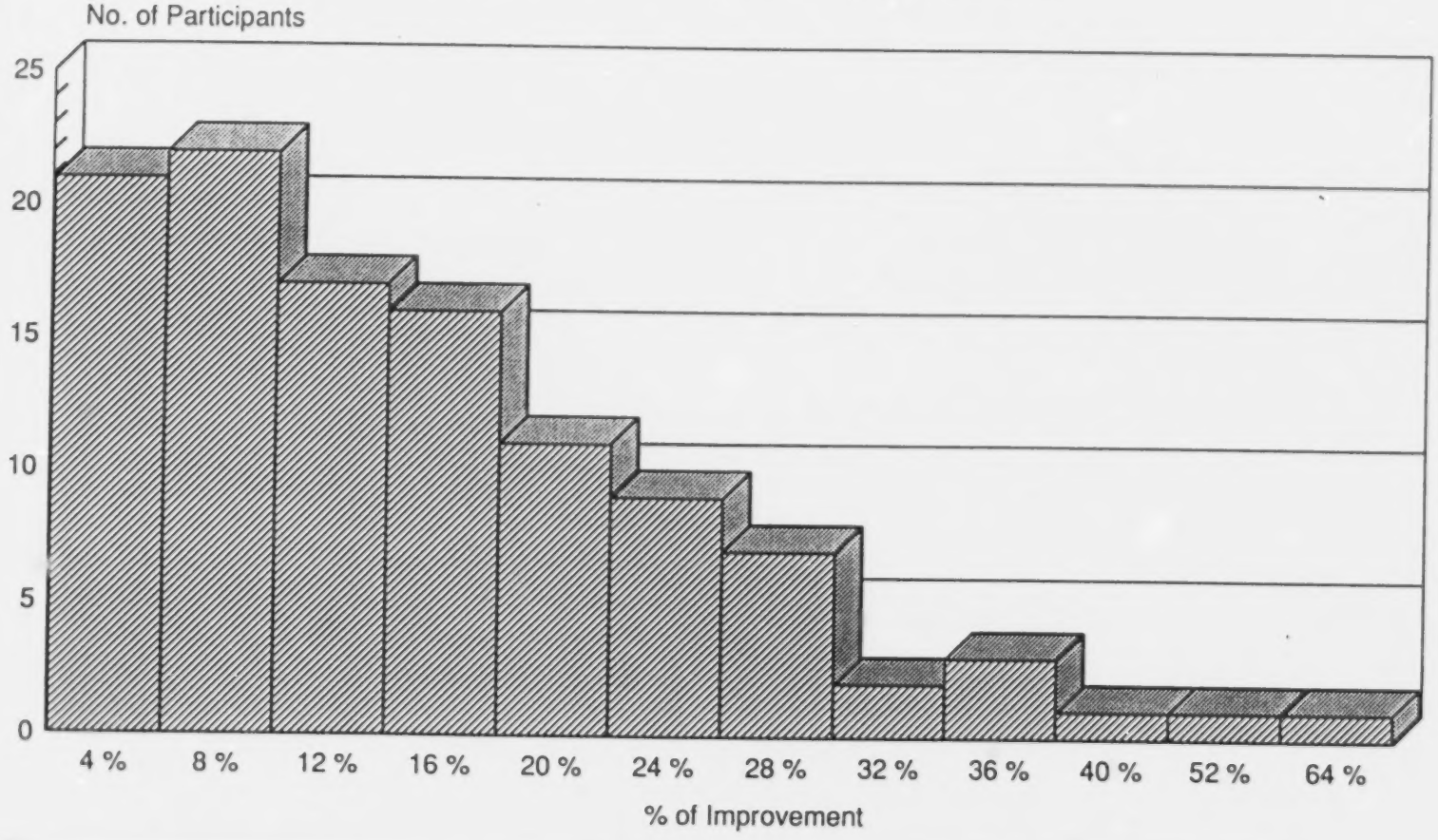
Number and Percentage
of Overall Post Test Score Results
Comparted to Pre Test Scores

Post Test Score Results	Total No.	Percentage
Overall Improvement	111	87.4
20% or Greater Improvement	35	27.5
No Improvement	16	12.6

The percentage of overall improvement between pre and post test scores ranged anywhere from four percent to 64 percent. The number of participants and

the percentage of improvement demonstrated, is graphically depicted in Figure Two:

Figure Two
Number of Participants Demonstrating Overall Improvement in Test Scores by Percentage of Improvement



A practicum objective was established for each of the five designated areas of instruction. The pre and post test evaluation tool was the instrument utilized to ascertain if the objective was met. With 127 participants and five questions per test category on each individual test, there was a total of 635 possible questions for each category on both the pre and post test. For the first objective, to dispel commonly held myths regarding HIV infection and AIDS, there was a mean improvement in pre and post test scores of 3.9 percent.

The second objective was to increase the level of knowledge regarding the modes of HIV transmission. The pre and post test scores revealed a mean improvement of 2.9 percent in this area.

The educational program's third objective was to enhance awareness of HIV infection and AIDS in children. Here, a mean improvement between pre and post test scores was of 11.5 percent.

The fourth objective was to improve the level of knowledge regarding the mechanics of condom use and application. The pre and post test evaluation tool revealed the mean percentage of improvement for this category to be 33.3 percent.

The final objective for the practicum was to personalize the risk for AIDS. The mean improvement between pre and post tests for this category was 10.7 percent. Table Two reflects the total number and mean percentage of pre test errors per test category:

Table Two

Number and Mean Percentage
of Pre-Test Errors Per
Test Category

Category	Total Possible No. of Questions	Total No. Answered in Error	Mean Percentage Wrong
Myths	635	126	19.8
Babies	635	150	23.6
Transmission	635	64	10.1
Condoms	635	257	40.5
Personalizing Risk	635	110	17.3

Table Three reflects the total number and mean percentage of post test errors per test category:

Table Three

Number and Mean Percentage
of Post-Test Errors Per
Test Category

Category	Total Possible No. of Questions	Total No. Answered in Error	Mean Percentage Wrong
Myths	635	101	15.9
Babies	635	77	12.1
Transmission	635	46	7.2
Condoms	635	46	7.2
Personalizing Risk	635	42	6.6

A comparison of the mean percentage of errors between pre and post tests, for each test category, yields a mean percentage of improvement. This is revealed in Table Four:

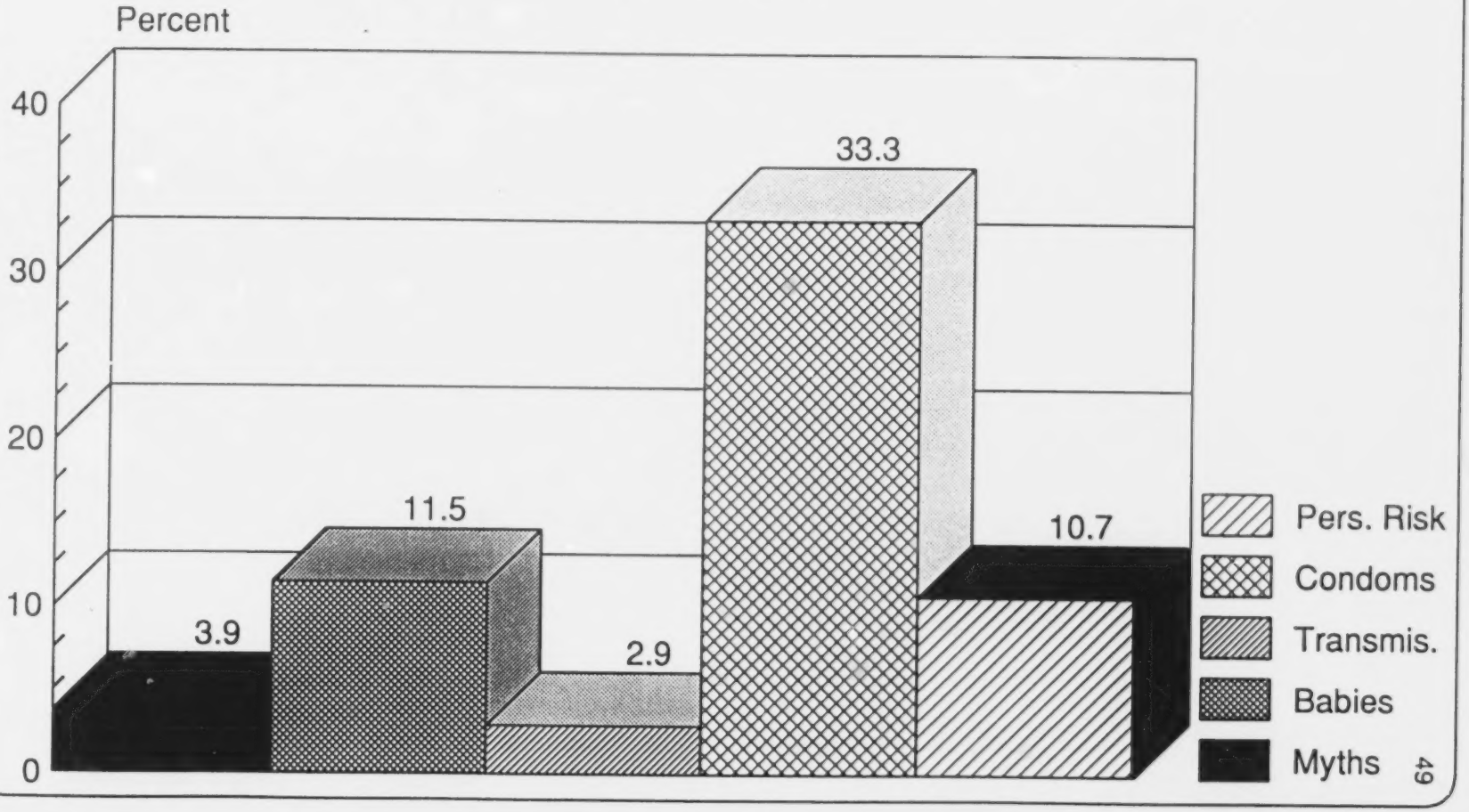
Table Four

Mean Percentage of Pre-Test Scores
Compared with Mean Percentage
of Post-Test Errors
per Test Category

Category	Pre-test Mean %	Post-test Mean %	Mean Percentage Improvement
Myths	19.8	15.9	3.9
Babies	23.6	12.1	11.5
Transmission	10.1	7.2	2.9
Condoms	40.5	7.2	33.3
Personalizing Risk	17.3	6.6	10.7

The mean percentage of improvement per each instructional category is graphically depicted in Figure Three:

Figure Three
Mean Percent Improvement Between
Pre- and Post-Test Scores For
Each Test Category



Discussion Session

In analysis of these findings, improvement was demonstrated for each of the five testing categories. However, with strict adherence to the anticipated level of improvement prescribed in the practicum proposal, only the fourth objective, that which addressed the instructional area of condoms, was satisfied.

In an attempt to explain these findings, each objective will be evaluated. In reference to dispelling myths, long held beliefs (correct or otherwise), are generally difficult to dismiss in one educational session. This is evidenced by 126 total myth questions answered erroneously on the pre test in comparison to 101 answered incorrectly on the post test. In analyzing the data from the pre and post tests, 25 of the 127 participants believed on both pre and post tests, that HIV infection could be acquired through casual contact. An additional 12 individuals (one of whom was known to be HIV positive) asserted that the virus could easily be acquired in the same fashion as the common cold. Finally, six of the 127 participants believed on both pre and post tests, that HIV infection and AIDS is solely a disease of gay men and IV drug users. These findings correlate with those cited by Valdiserri (1989). Here, reference is made to a 1987 survey of over three thousand Americans, 18 years of age and older. Thirty six percent thought that food in a restaurant prepared by an HIV infected person, was a source of infection. In addition, 18 percent believed that working near a PWA was a risk and 35 percent asserted that insects could spread the virus.

Interestingly, though commonly held misconceptions regarding HIV transmission were maintained, the area where the participants were found to be

the most knowledgeable was transmission. Only 64 total questions in this category were missed on the pre test, with an improvement to a total of 46 questions missed on the post test. It is therefore speculated that the small percentage of improvement between pre and post test scores in this category is attributable to the overall accuracy of information the target population had prior to the implementation process. What is noteworthy, is that although the majority of the population appears well versed on how the virus is actually spread, many still believe myths regarding inaccurate modes of transmission.

Another curious finding in the data, relates to information regarding personalization of the risk for infection. Though individuals will assert that the HIV virus is as easy to catch as the common cold or can be acquired through casual contact, when asked if they believed if they were at risk for acquiring the infection, the majority stated "no". Table Five reflects the pre and post test responses to the "Perceived Risk for AIDS" and categorizes these responses by race and gender:

Table Five

"Perceived Risk For AIDS" - Post Test Results

Pre-Test "No Risk"	Race/Gender							Total No./ Total No. Participants	%
	C ♀	C ♂	B ♀	B ♂	Ha ♂	H ♀	H ♂		
No	28	5	2	0	1	5	1	80/127	63
Yes	0	0	1	0	0	1	0	3/127	2.4
Unsure	0	0	4	0	0	0	0	4/127	3.1
No Answer	0	0	0	1	0	0	0	1/127	0.8

Pre-test "Yes"	Race/Gender							Total No./ Total No. Participants	%
	C ♀	C ♂	B ♀	B ♂	Ha ♂	H ♀	H ♂		
No	2	1	3	0	0	0	0	6/127	4.7
Yes	4	0	6	1	0	1	0	12/127	9.5
Unsure	0	0	0	0	0	0	0	0/127	0
No Answer	0	1	0	0	0	0	0	1/127	0.8

Pre-test "Unsure"	Race/Gender							Total No./ Total No. Participants	%
	C ♀	C ♂	B ♀	B ♂	Ha ♂	H ♀	H ♂		
No	3	0	2	0	0	0	0	5/127	3.9
Yes	0	0	2	0	0	0	0	2/127	1.6
Unsure	2	0	4	0	0	1	0	7/127	5.5
No Answer	1	0	2	0	0	1	0	4/127	3.1

Pre-test "No Answer"	Age/Gender							Total No./ Total No. Participants	%
	C ♀	C ♂	B ♀	B ♂	Ha ♂	H ♀	H ♂		
No	0	0	1	0	0	0	0	1/127	0.8
Yes	0	0	1	0	0	0	0	1/127	0.8
Unsure	0	0	0	0	0	0	0	0/127	0
No Answer	0	0	0	0	0	0	0	0/127	0

Legend: Race: C=Caucasian; B=Black; Ha=Haitian; H=Hispanic
Sex: ♀ = Female; ♂ = Male

The inclusion of this question regarding one's perceived risk for AIDS was felt by the author, to be one of the most important questions in the whole evaluation tool. However, as shown in Table Five, only a total of six of the 127 participants, or 3.8 percent had an affirmative change in their perception of risk from the pre to the post test. These findings concur with those found in a San Francisco survey cited by the Congress of the U.S., Office of Technology Assessment (1988). Here, many respondents reported having sexual partners in high risk groups for AIDS, yet less than one-third felt personally threatened.

Though this question of perceived risk is vital to address when providing AIDS education, the validity of the responses to this question can be disputed. This was evidenced by the author's observation of the responses of individuals known to be HIV positive or known to get tested frequently. Two of the three individuals who were known to be HIV positive identified themselves not to be at risk for infection on both pre and post tests. In addition, two of the three individuals who reported getting tested frequently because of a known exposure, also identified themselves not to be at risk on both pre and post tests. Explanations for these responses may center around the prejudice associated with this disease. Even though the tests are anonymous, one may be reluctant to identify themselves to be at risk. In addition, an individual may not want the person sitting alongside of them to see a positive response to this question. Furthermore, as might have been the situation with those individuals who carry the virus, or who have a known exposure, putting this type of response in written form validates the risk. These individuals may not have been emotionally prepared to do this. To

support this assumption, preliminary results of a cross sectional study on women who have engaged in prostitution, being conducted by the CDC and cited by the Congress of U.S., Office of Technology Assessment (1988) revealed the following. Only 13 percent of these women who were tested for HIV returned to the clinic to learn their results. Knowing you are at risk and validating it, are two different things.

In reference to the objective which addressed condoms, as stated previously, a mean improvement of 33.3 percent was demonstrated. Of all the instructional categories, condom education was the one where the majority of participants were least informed before the implementation process. This finding of decreased knowledge regarding condoms, concurred with that reported by the Congress of U.S., Office of Technology Assessment (1988). This reference revealed there to be less awareness of safe sex practices among Blacks and Hispanics. The amount of improvement seen between pre and post test scores could be attributable to the general lack of knowledge the population had prior to the implementation process. The enhancement in knowledge seen could also be attributable to the reiteration of condom information and the condom demonstration, provided just prior to the administration of the post test.

Finally, in reference to the objective which addressed enhancing awareness of HIV infection and AIDS in children, as stated previously, a mean improvement of 11.5 percent was seen. Most of the participants were aware of the risk of perinatal transmission, however, many were unaware of the ravages of the disease in terms of morbidity and mortality. It would have been extremely beneficial (and

perhaps a more substantial improvement between pre and post test scores would have been demonstrated), if the testimony of HIV infected women who have transmitted the virus to their children, could have been incorporated into the video. The author met with and interviewed three women in this situation. However, because of the prejudice associated with AIDS, all three declined the opportunity to be in the video, in order to protect their children's anonymity. In addition, the author spent a great deal of time with the mother of a two year old little girl dyeing of AIDS in a pediatric intensive care unit. Though the child's anonymity would have been respected in filming, the mother had not yet dealt with her child's diagnosis, let alone her own diagnosis and therefore could not consent to her daughter's participation in the video. The author speculates that inclusion of these individuals in the video had the potential to make a greater impact on the participants, clearly portraying the gravity of pediatric AIDS in this community and country.

Recommendations

The recommendations the author has for the practicum would be to translate the video into Spanish so that the entire high risk segment of this population can be reached. In addition, the author recommends the inclusion of children with AIDS and their mothers in the video. This should be incorporated in an attempt to accentuate to the target population the pediatric AIDS crisis at hand and to validate their possible role in it.

In reference to the continuation of the program in the work setting, the author has already met with the nursing staff and has gained their support to continue the implementation process. The next step shall be to contact the hospital administration to pursue this proposal with them and to also investigate the possibility of conducting anonymous HIV testing. This testing would need to be performed on minority childbearing women, to determine if the educational program proves beneficial in helping to decrease the overall incidence of perinatal HIV transmission over time.

Follow-On

As stated previously, the author intends to share the results of the practicum with the county Comprehensive AIDS Program, so that the results may be utilized in a grant proposal to support the need for funding educational programs. In addition, should monies be made available, this organization has stated an interest in developing a professionally done version of the video and a Spanish version. The possibility also exists for the author to collaborate with this agency in the development of videos targeted at other populations, such as teenagers.

The author is also in the process of developing abstracts of the practicum for various associations, namely the Association of Nurses in AIDS Care and The National Association of Neonatal Nurses. These abstracts will be reviewed for possible presentation at each association's annual national conference. In addition, there is a call for citations on nursing interventions and strategies implemented to reduce the transmission of HIV. This call was presented in "Image", the official journal of Sigma Theta Tau International's Honor Society of

Nursing. A citation of the practicum will be developed by the author and forwarded to this publication for review.

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"Appendix"

Questionnaire for HIV Infected Women

1. What did you know about AIDS before you became infected?

2. If you could have been in an AIDS prevention class, what kind of information about AIDS would you have found helpful?

3. What things did you used to believe or think about AIDS or HIV infection before, which you know now are untrue?

4. What kinds of things do women need to know to protect them from becoming infected with HIV?

5. What do you think are the best ways to get women to practice safe sex?

6. What kind of information do you think should be included in an AIDS teaching program?

7. What kinds of information would you like to tell other women about this disease?

8. What kinds of information would you like to tell other women about your life the way it is now?

9. What kinds of information would you like to tell other women about your children?

10. What information should a woman's sex partner know about AIDS and HIV infection?

Appendix B
AIDS Pre/Post-test

1. Do you think you are at risk for catching AIDS?

   Yes No Unsure

2. How do you know if someone is infected with the AIDS virus?
   a. they always look like they are dying
   b. they always look sick
   c. there is no way to know for sure unless the person has a special HIV blood test for the AIDS virus
   d. they look fine but always feel sick

3. If you are infected with the virus which causes AIDS and are pregnant
   a. your baby can only catch the virus if you are sick
   b. your baby has a great chance (1 in 3) of catching the AIDS virus from you
   c. your baby can't catch the disease from you

Answer "T" for true or "F" for false for questions 4 through 25

T F 4. You can catch the AIDS virus by sharing drug needles and syringes with a person infected with the AIDS virus

T F 5. A baby can catch the AIDS virus from his/her mother if the mother is infected with the AIDS virus (is HIV positive)

T F 6. AIDS is as easy to catch as the common cold

T F 7. You can only catch AIDS if you are gay (homosexual) or use IV drugs

T F 8. If the IV drug user cleans the needles and syringes with water, the virus which causes AIDS will be killed

T F 9. The kind of condom (rubber) the man wears doesn't matter

T F 10. In some cities in the United States, over one half of the IV drug users are infected with the virus which causes AIDS

T F 11. A child with AIDS can become mentally retarded

T F 12. You can protect yourself from catching AIDS during sex if the man wears a condom

T F 13. Latex condoms give the best protection against catching AIDS

T F 14. In the next few years, AIDS will be the number one killer of women your age

T F 15. You can catch AIDS if you have casual contact with someone who is infected with the virus which causes AIDS

T F 16. If you have unprotected sex with a man who is <u>not</u> an IV drug user, you <u>cannot</u> catch the AIDS virus

T F 17. Very few children get AIDS

T F 18. If the condom has a spermicide (something which kills sperm), there will be better protection from catching AIDS

T F 19. You can catch AIDS the first time you have unprotected sex with a person infected with the AIDS virus

T F 20. Most women infected with the AIDS virus today, were either IV drug users themselves or they had sex with an IV drug user

T F 21. It is o.k. to reuse a condom

T F 22. Most babies who are infected with the AIDS virus die from AIDS before they are two years old

T F 23. Condoms can break if you use vaseline, baby oil or shortening to lubricate them

T F 24. You can catch the AIDS virus if you have unprotected sex with a person infected with the AIDS virus

T F 25. There is no known cure for AIDS

Appendix C
Model Release

Place_____

Topic Educational video on AIDS

I, the undersigned, do hereby grant to Gail Nimphius and to her employees or assigns, permission to video tape images of the following named individual:

_____

for the express purpose of use in an educational video on AIDS. No reference shall be made to the individual by name who is being filmed, unless authorized prior to by that individual and by separate agreement to the same.

The undersigned warrants that he/she has the legal authority and capacity to sign this document on behalf of self or the individual so indicated, to release Gail Nimphius from any or all claims or causes or action which may or may not arise as the result of this video.

Use of this educational video and its contents shall include but not be limited to: publication, display, advertising, resale.

Signature_____

Relation to Subject_____

Witness_____ Date_____ Time____

The subject is unable to sign for him or herself because:

_____

I, therefore hereby grant permission as the parent or legal guardian for the above named individual.

Signature_____

Relation to Subject_____

Witness_____ Date_____Time____

Appendix D

Data Report Sheet - Week Number One

Participant Data		At Risk For AIDS		Pre-test Score		Pre-test Errors					Post Test Score		Post Test Errors					% Improved	
Race	Sex	Pre	Post	No. Wrong	%	M	B	T	C	P	No. Wrong	%	M	B	T	C	P	%	≥ 20 %
H	♂	N	Y	11	56	0	3	3	3	2	4	84	0	3	1	0	0	28	Y
H	♀	N	N	15	40	4	2	3	3	3	5	80	4	0	0	0	1	40	Y
B	♀	N	N	6	76	0	2	0	2	2	4	84	1	1	1	0	1	8	N
C	♀	N	N	2	92	0	2	0	0	0	0	100	0	0	0	0	0	8	N
C	♀	Y	Y	3	88	0	1	0	2	0	0	100	0	0	0	0	0	12	N
H	♀	Y	Y	4	84	0	1	0	1	2	0	100	0	0	0	0	0	16	N
B	♀	N	N	7	72	1	2	0	3	1	1	96	1	1	0	0	0	24	Y
B	♀	N	N	6	76	1	1	0	4	0	1	96	1	0	0	0	0	20	Y
B	♀	N	N	1	96	0	0	0	1	0	0	100	0	0	0	0	0	4	N
C	♀	N	N	5	80	0	2	0	2	1	1	96	1	0	1	0	0	16	N
C	♀	N	N	1	96	0	0	0	1	0	0	100	0	0	0	0	0	4	N
B	♀	N	N	3	88	1	1	0	0	1	2	92	0	0	0	1	1	4	N
H	♀	U	N/A	21	16	5	5	4	3	4	15	40	3	3	2	4	3	24	Y
B	♀	U	U	5	80	1	1	0	2	1	0	100	0	0	0	0	0	20	Y
				Totals		13	23	10	27	17			11	8	5	5	6		

Legend: Race: H=Hispanic; B=Black; C=Caucasian, Ha=Haitian
Sex: ♀ = Female; ♂ = Male
Test Questions: M=myths; B=babies; T=transmission; C=condoms; P=personalizing risk
At Risk For AIDS (Pre- and Post-Test Questions): Y=Yes; N=No; U=Unsure; N/A=No Answer

Appendix D

Data Report Sheet - Week Number Two

Participant Data		At Risk For AIDS		Pre-test Score		Pre-test Errors					Post Test Score		Post Test Errors					% Improved	
Race	Sex	Pre	Post	No. Wrong	%	M	B	T	C	P	No. Wrong	%	M	B	T	C	P	%	≥ 20 %
B	♀	Y	N	6	76	1	1	1	3	0	1	96	1	0	0	0	0	20	Y
B	♀	N	N	8	68	2	1	2	3	0	1	96	1	0	0	0	0	28	Y
C	♀	N	N	5	80	0	2	0	3	0	1	96	0	1	0	0	0	16	N
C	♀	U	N/A	5	80	1	1	0	3	0	2	92	1	1	0	0	0	12	N
C	♂	N	N	6	76	1	1	0	2	2	2	92	1	1	0	0	0	16	N
B	♀	N	N	9	64	2	2	1	2	2	9	64	3	1	2	3	0	0	N
C	♀	N	N	3	88	1	0	0	2	0	0	100	0	0	0	0	0	12	N
C	♀	U	N	1	96	1	0	0	0	0	2	92	0	1	0	1	0	-4	N
C	♂	N	N	3	88	0	1	0	1	1	1	96	0	1	0	1	0	8	N
B	♀	Y	Y	4	84	0	3	0	1	0	2	92	0	2	0	0	0	8	N
B	♀	U	U	7	72	0	3	1	3	0	3	88	1	2	0	0	0	16	N
B	♀	N	N	6	76	2	1	0	2	1	10	60	3	1	1	2	3	-16	N
B	♀	Y	Y	1	96	0	0	0	0	1	0	100	0	0	0	0	0	4	N
C	♀	N	N	4	84	2	0	1	1	0	4	84	2	1	1	0	0	0	N
B	♀	N	N	5	80	1	0	0	4	0	0	100	0	0	0	0	0	20	Y
				Totals		14	16	6	30	7			13	12	4	7	3		

Legend: Race: H=Hispanic; B=Black; C=Caucasian, Ha=Haitian

Sex: ♀ = Female; ♂ = Male

Test Questions: M=myths; B=babies; T=transmission; C=condoms; P=personalizing risk

At Risk For AIDS (Pre- and Post-Test Questions): Y=Yes; N=No; U=Unsure; N/A=No Answer

Appendix D

Data Report Sheet - Week Number Three

Participant Data		At Risk For AIDS		Pre-test Score		Pre-test Errors					Post Test Score		Post Test Errors					% Improved	
Race	Sex	Pre	Post	No. Wrong	%	M	B	T	C	P	No. Wrong	%	M	B	T	C	P	%	≥ 20 %
B	♀	N	N	10	60	3	1	0	3	3	5	80	2	1	0	0	2	20	Y
C	♀	N	N	4	84	2	0	0	2	0	0	100	0	0	0	0	0	16	N
B	♀	N	N	4	84	1	1	0	1	1	2	92	1	0	0	0	1	8	N
C	♀	N	N	5	80	0	2	0	2	1	1	96	0	1	0	0	0	16	N
C	♀	U	U	4	84	0	1	0	3	0	1	96	0	1	0	0	0	12	N
B	♀	N	N	4	84	1	2	0	1	0	3	88	1	1	1	0	0	4	N
C	♀	N	N	2	92	0	0	0	1	1	0	100	0	0	0	0	0	8	N
C	♀	Y	Y	4	84	0	1	0	3	0	0	100	0	0	0	0	0	16	N
B	♀	U	N/A	7	72	2	2	1	1	1	2	92	2	0	0	0	0	20	Y
B	♀	Y	N	10	60	4	2	1	1	1	6	76	0	1	1	3	1	16	N
Ha	♂	N	N	7	72	2	2	0	2	1	8	68	2	3	1	0	2	4	N
B	♀	N	N	4	84	0	1	1	1	1	2	92	0	0	1	0	1	8	N
				Totals		15	15	3	21	10			8	8	4	3	7		

Legend: Race: H=Hispanic; B=Black; C=Caucasian, Ha=Haitian
Sex: ♀ = Female; ♂ = Male
Test Questions: M=myths; B=babies; T=transmission; C=condoms; P=personalizing risk
At Risk For AIDS (Pre- and Post-Test Questions): Y=Yes; N=No; U=Unsure; N/A=No Answer

Appendix D

Data Report Sheet - Week Number Four

Participant Data		At Risk For AIDS		Pre-test Score		Pre-test Errors					Post Test Score		Post Test Errors					% Improved	
Race	Sex	Pre	Post	No. Wrong	%	M	B	T	C	P	No. Wrong	%	M	B	T	C	P	%	≥ 20 %
B	♂	Y	Y	6	76	3	1	0	1	1	6	76	3	0	1	1	0	0	N
C	♀	N	N	6	76	2	1	0	2	1	0	100	0	0	0	0	0	24	Y
B	♀	N	N	3	88	0	0	0	3	0	2	92	2	0	0	0	0	4	N
C	♀	N	N	7	72	1	2	1	2	2	4	84	0	2	1	0	1	12	N
C	♀	N	N	4	84	1	0	0	3	0	0	100	0	0	0	0	0	16	N
C	♀	N	N	2	92	0	0	1	1	0	0	100	0	0	0	0	0	8	N
B	♀	N	N/A	19	24	2	5	3	5	4	3	88	1	1	1	0	0	64	Y
B	♂	N	N	6	76	2	0	1	3	0	4	84	2	0	1	1	0	8	N
C	♀	Y	N	5	80	0	2	0	2	1	0	100	0	0	0	0	0	20	Y
B	♀	U	N	1	96	0	0	0	1	0	1	96	0	0	0	0	1	0	N
B	♀	U	N	8	68	1	3	0	3	1	4	84	1	2	1	0	0	16	N
				Totals		12	14	6	26	10			9	5	5	2	2		

Legend: Race: H=Hispanic; B=Black; C=Caucasian, Ha=Haitian
Sex: ♀ = Female; ♂ = Male
Test Questions: M=myths; B=babies; T=transmission; C=condoms; P=personalizing risk
At Risk For AIDS (Pre- and Post-Test Questions): Y=Yes; N=No; U=Unsure; N/A=No Answer

Appendix D

Data Report Sheet - Week Number Five

Participant Data		At Risk For AIDSNN		Pre-test Score		Pre-test Errors					Post Test Score		Post Test Errors					% Improved	
Race	Sex	Pre	Post	No. Wrong	%	M	B	T	C	P	No. Wrong	%	M	B	T	C	P	%	≥ 20 %
C	♀	N	N	5	80	1	0	0	4	0	0	100	0	0	0	0	0	20	Y
B	♀	N/A	Y	22	12	5	4	4	4	5	20	20	5	3	4	4	4	8	N
B	♀	N	N	5	80	2	2	0	1	0	6	76	4	1	0	1	0	4	N
B	♀	N	N	10	60	2	2	0	3	1	1	96	0	1	0	0	0	36	Y
B	♀	U	Y	5	80	1	1	0	2	1	2	92	1	1	0	0	0	12	N
C	♀	U	N	2	92	0	1	0	1	0	2	92	0	1	1	0	0	0	N
B	♀	N	N	9	64	2	2	3	2	2	12	52	2	3	2	3	2	-12	N
B	♀	N	N	10	60	4	3	0	3	0	8	68	3	0	0	2	3	8	N
B	♀	N	N	4	84	0	2	0	1	1	5	80	1	1	2	0	1	-4	N
B	♀	N	N	2	92	0	0	0	2	0	0	100	0	0	0	0	0	8	N
C	♀	N	N	3	88	0	1	0	1	1	2	92	0	1	0	0	1	4	N
B	♀	N	N	6	76	1	1	0	3	1	1	96	0	1	0	0	0	20	Y
B	♀	N	N	5	80	2	1	0	2	0	2	92	1	0	0	1	0	12	N
B	♂	Y	Y	3	88	0	1	0	1	1	1	96	0	0	0	0	1	8	N
B	♀	N	N	15	40	4	2	3	5	1	2	92	1	0	0	1	0	52	Y
C	♀	N	N	4	80	2	0	0	2	0	3	88	1	1	1	0	0	4	N
C	♂	N	N	7	72	2	3	1	1	0	3	88	1	1	1	0	0	16	N
				Totals		28	26	11	38	14			20	15	11	12	12		

Legend: Race: H=Hispanic; B=Black; C=Caucasian, Ha=Haitian
Sex: ♀ = Female; ♂ = Male
Test Questions: M=myths; B=babies; T=transmission; C=condoms; P=personalizing risk
At Risk For AIDS (Pre- and Post-Test Questions): Y=Yes; N=No; U=Unsure; N/A=No Answer

Appendix D

Data Report Sheet - Week Number Six

Participant Data		At Risk For AIDS		Pre-test Score		Pre-test Errors					Post Test Score		Post Test Errors					% Improved	
Race	Sex	Pre	Post	No. Wrong	%	M	B	T	C	P	No. Wrong	%	M	B	T	C	P	%	≥ 20 %
B	♀	N	N	1	96	1	0	0	0	0	0	100	0	0	0	0	0	4	N
B	♀	N	N	2	92	0	1	0	1	0	1	96	0	1	0	0	0	4	N
B	♀	N	N	5	80	1	1	0	1	2	3	88	1	1	0	0	1	8	N
C	♀	N	N	4	84	2	1	0	1	0	1	96	0	1	0	0	0	12	N
C	♀	N	N	2	92	0	1	0	1	0	0	100	0	0	0	0	0	8	N
C	♀	U	N	5	80	0	1	0	4	0	2	92	0	1	0	0	1	12	N
B	♀	Y	Y	5	80	0	2	0	1	2	1	96	0	0	1	0	0	16	N
B	♀	N	N	1	96	1	0	0	0	0	0	100	0	0	0	0	0	4	N
B	♀	N	N	2	92	0	0	0	1	1	0	100	0	0	0	0	0	8	N
C	♀	N	N	5	80	0	1	0	3	1	2	92	0	1	0	0	1	12	N
C	♀	N	N	3	88	1	0	0	2	0	3	88	2	1	0	0	0	0	N
C	♂	Y	N/A	4	84	0	1	1	2	0	2	92	0	1	1	0	0	8	N
B	♀	N/A	N	9	64	1	1	2	4	1	2	92	1	1	0	0	0	28	Y
B	♀	Y	N	2	92	0	0	0	2	0	0	100	0	0	0	0	0	8	N
				Totals		6	10	3	23	7			4	8	2	0	3		

Legend: Race: H=Hispanic; B=Black; C=Caucasian, Ha=Haitian
Sex: ♀ = Female; ♂ = Male
Test Questions: M=myths; B=babies; T=transmission; C=condoms; P=personalizing risk
At Risk For AIDS (Pre- and Post-Test Questions): Y=Yes; N=No; U=Unsure; N/A=No Answer

Appendix D

Data Report Sheet - Week Number Seven

Participant Data		At Risk For AIDS		Pre-test Score		Pre-test Errors					Post Test Score		Post Test Errors					% Improved	
Race	Sex	Pre	Post	No. Wrong	%	M	B	T	C	P	No. Wrong	%	M	B	T	C	P	%	≥ 20 %
B	♀	U	N/A	8	68	0	2	1	2	3	0	100	0	0	0	0	0	32	Y
B	♀	N	U	7	72	0	1	2	2	2	5	80	0	1	2	2	0	8	N
H	♀	N	N	0	100	0	0	0	0	0	1	96	1	0	0	0	0	-4	N
C	♂	N	N	1	96	0	0	0	1	0	0	100	0	0	0	0	0	4	N
B	♀	U	Y	7	72	1	1	0	2	3	1	96	0	1	0	0	0	24	Y
H	♀	N	N	8	68	1	2	0	3	2	2	92	2	0	0	0	0	24	Y
B	♀	N	N	3	88	2	0	0	1	0	5	80	3	1	1	0	0	-8	N
B	♀	N	N	6	76	0	0	0	3	3	0	100	0	0	0	0	0	24	Y
C	♀	Y	Y	3	88	1	2	0	0	0	0	100	0	0	0	0	0	12	N
C	♂	N	N	8	68	1	1	0	3	3	2	92	0	1	0	0	1	24	Y
B	♀	N	Y	1	96	1	0	0	0	0	1	96	1	0	0	0	0	0	N
					Totals	7	9	3	17	16			7	4	3	2	1		

Legend: Race: H=Hispanic; B=Black; C=Caucasian, Ha=Haitian
Sex: ♀ = Female; ♂ = Male
Test Questions: M=myths; B=babies; T=transmission; C=condoms; P=personalizing risk
At Risk For AIDS (Pre- and Post-Test Questions): Y=Yes; N=No; U=Unsure; N/A=No Answer

Appendix D

Data Report Sheet - Week Number Eight

Participant Data		At Risk For AIDS		Pre-test Score		Pre-test Errors					Post Test Score		Post Test Errors					% Improved	
Race	Sex	Pre	Post	No. Wrong	%	M	B	T	C	P	No. Wrong	%	M	B	T	C	P	%	≥ 20 %
B	♀	N	N	5	80	0	2	1	1	1	2	92	0	1	1	0	0	12	N
B	♀	N	N	9	64	2	1	0	4	2	2	92	1	0	0	0	1	28	Y
B	♀	Y	Y	2	92	0	0	0	2	0	3	88	2	1	0	0	0	-4	N
C	♀	N	N	5	80	0	1	0	2	2	0	100	0	0	0	0	0	20	Y
C	♀	N	N	3	88	1	0	0	2	0	0	100	0	0	0	0	0	12	N
C	♀	N	N	6	76	0	1	0	3	2	2	92	0	1	0	0	1	16	N
C	♀	N	N	7	72	0	2	0	4	1	0	100	0	0	0	0	0	28	Y
H	♀	N	N	12	52	1	2	4	4	1	3	88	1	0	1	0	1	36	Y
H	♂	N	N	6	76	1	2	2	1	0	7	72	2	0	2	2	1	-4	N
C	♀	N	N	2	92	0	0	0	2	0	1	96	0	0	0	1	0	4	N
C	♀	N	N	2	92	0	0	0	2	0	1	96	0	0	0	1	0	4	N
B	♀	N	N	4	84	0	2	0	2	0	1	96	0	1	0	0	0	12	N
C	♀	N	N	3	88	0	1	0	1	1	0	100	0	0	0	0	0	12	N
				Totals		5	14	7	30	10			6	4	4	4	4		

Legend: Race: H=Hispanic; B=Black; C=Caucasian, Ha=Haitian
Sex: ♀ = Female; ♂ = Male
Test Questions: M=myths; B=babies; T=transmission; C=condoms; P=personalizing risk
At Risk For AIDS (Pre- and Post-Test Questions): Y=Yes; N=No; U=Unsure; N/A=No Answer

Appendix D

Data Report Sheet - Week Number Nine

Participant Data		At Risk For AIDS		Pre-test Score		Pre-test Errors					Post Test Score		Post Test Errors					% Improved	
Race	Sex	Pre	Post	No. Wrong	%	M	B	T	C	P	No. Wrong	%	M	B	T	C	P	%	≥ 20 %
B	♀	N	N	15	40	4	3	2	4	2	9	64	3	2	2	2	0	24	Y
B	♀	N	U	3	88	1	1	0	1	0	1	96	1	0	0	0	0	8	N
C	♀	N	N	0	100	0	0	0	0	0	0	100	0	0	0	0	0	0	N
H	♀	N	Y	4	84	1	1	0	2	0	2	92	1	1	0	0	0	8	N
B	♀	U	U	8	68	1	2	1	3	1	1	96	1	0	0	0	0	28	Y
C	♂	Y	N	5	80	1	0	2	2	0	0	100	0	0	0	0	0	20	Y
C	♀	U	U	3	88	0	0	0	1	2	2	92	0	1	0	0	1	4	N
B	♀	N	N	4	84	0	0	0	3	1	3	88	0	2	0	1	0	4	N
B	♀	N	N	8	68	2	2	1	2	1	4	84	2	1	1	0	0	16	N
C	♀	Y	N	1	96	0	0	0	1	0	0	100	0	0	0	0	0	4	N
H	♀	N	N	2	92	0	1	0	0	1	1	96	0	1	0	0	0	4	N
H	♀	U	U	5	80	1	2	0	1	1	4	84	0	1	2	1	0	4	N
B	♀	N	U	6	76	2	1	0	3	0	3	88	2	0	1	0	0	12	N
B	♀	N	U	9	64	0	3	1	2	3	3	88	1	1	0	1	0	24	Y
				Totals		13	16	7	25	12			11	10	6	5	1		

Legend: Race: H=Hispanic; B=Black; C=Caucasian, Ha=Haitian
Sex: ♀ = Female; ♂ = Male
Test Questions: M=myths; B=babies; T=transmission; C=condoms; P=personalizing risk
At Risk For AIDS (Pre- and Post-Test Questions): Y=Yes; N=No; U=Unsure; N/A=No Answer

Appendix D

Data Report Sheet - Week Number Ten

Participant Data		At Risk For AIDS		Pre-test Score		Pre-test Errors					Post Test Score		Post Test Errors					% Improved	
Race	Sex	Pre	Post	No. Wrong	%	M	B	T	C	P	No. Wrong	%	M	B	T	C	P	%	≥ 20 %
C	♀	Y	Y	4	84	2	0	0	2	0	0	100	0	0	0	0	0	16	N
B	♀	U	U	8	68	2	1	1	4	0	9	64	3	1	0	3	2	-4	N
B	♀	N	N	13	48	3	2	2	4	2	5	76	3	2	1	0	0	28	Y
B	♀	N	N	11	56	4	1	2	2	2	9	64	4	0	1	3	1	8	N
B	♀	N	N	11	56	2	1	3	4	1	2	92	2	0	0	0	0	36	Y
B	♀	N	N	8	68	0	2	0	4	2	100	0	0	0	0	0	0	32	Y
				Totals		13	7	8	20	7			12	3	2	6	3		

Legend: Race: H=Hispanic; B=Black; C=Caucasian, Ha=Haitian
Sex: ♀ = Female; ♂ = Male
Test Questions: M=myths; B=babies; T=transmission; C=condoms; P=personalizing risk
At Risk For AIDS (Pre- and Post-Test Questions): Y=Yes; N=No; U=Unsure; N/A=No Answer